**Mind and Body (NDIS Capacity Building)**

**Referral**

**Date: / /**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | **NDIS Number:** |  |
| **Date of Birth:** |  | **Plan Management Type:**  NDIA, Self or Plan Managed  (if Plan or Self managed please provide details) |  |
| **Participant Address:** |  |
| **Plan Start Date:** |  | **Plan End Date:** |  |
| **Contact Details to Arrange Assessment? Participant, Plan Nominee, NOK, or Service Provider?** |  | **Support Coordinator Contact Details:** |  |
| **Alerts/Allergies:** |  | **Urgency?** |  |

**Capacity Building Support/s Required?** If you have a preferred clinician please highlight, if referring to one or multiple supports please allocate hours accordingly next to each line item.

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| --- | --- | --- | --- |
| Item Number | Item Name and Clinician Options | Rate (STD TAS) | Hours / Funding |
| 15\_054\_0128\_1\_3 | Psychology – Assessment, recommendation, Therapy or Training  **Michael O’Donnell, Ulverstone and Wynyard**  **Tracey Spencer- Lloyd, Campbell Town - Therapeutic sessions only** | $ 234.83 |  |
| 15\_055\_0128\_1\_3 | Physiotherapy – Assessment, recommendation, Therapy or Training  **Jayne Grubits-King** | $ 224.62 |  |
| 15\_056\_0128\_1\_3 | Other Therapy Assessment, recommendation, Therapy or Training  **OT – Rosie Butler –** limited new participant intake  **OT – Jenna Berryman –** waitlist  **OT – Prathip Devaraj -** waitlist  **Speech Pathologist – Rachael Stocks -** waitlist | $ 193.99 |  |
| 15\_062\_0128\_3\_3  12\_025\_0128\_3\_3 | Dietician Consultation and Diet Plan Development  **Erica Cunningham** | $ 193.99 |  |
| 15\_200\_0126\_1\_3  12\_027\_0126\_3\_3 | Exercise physiology  **Lisa Broman** | $ 166.99 |  |
| 15\_051\_0114\_1\_3 | Community Nursing care for Continence Aid Assessment, recommendation and training support  **Jan Robinson – Registered Nurse** | $ 124.05 |  |

**Medical History and Primary Disability:**

**Social/Home situation:**

**Current services (Including other Allied Health professionals):**

**Reason for referral:** (EG; Psychology formal assessment or therapeutic sessions only? OT, Activities of daily living assessment, sensory, skill building, equipment? Please provide as much information as possible)

**NDIS Goals:**

1.

2.

3.

**Are recommendations required by plan end date? If so, please indicate when this needs to be submitted by …………………………. alternatively, if we have a waitlist ELPE Health will advise approx. timeframe for initial assessment.**

**Consent:**

**I ………………………………… consent for this referral to be sent and for relevant reports, history and information be shared with ELPE Health.**

**Participant or Participant's representative Name: (please print)**

**Signature:** **Date: / /**